APPENDIX

U.S. NUCLEAR REGULATORY COMMISSION REGION IV

NRC Inspection Report: 50-458/89-26

Operating License: NPF-47

Docket: 50-458

Licensee: Gulf States Utilities (GSU) P.O. Box 220 St. Francisville, Louisiana 70775

Facility Name: River Bend Station (RBS)

Inspection At: RBS, St. Francisville, Louisiana

Inspection Conducted: May 15-19, 1989

Inspector:

M. McNeill, Réactor Inspector, Materials and Quality Programs Section, Division of Reactor Safety

Approved:

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. Barnes, Chief, Materials and Quality Programs Section, Division of Reactor Safety 6/14-189 Date

Inspection Summary

Inspection Conducted May 15-19, 1989 (Report 50-458/89-26)

Areas Inspected: Routine, unannounced inspection of action on previously identified inspection findings, inservice inspection (ISI) data review, and corrective actions.

Results: The observations on ISI data review found the licensee activities satisfactory in this area in regard to a recent finding of an indication in the feedwater nozzle. The observations of the corrective action program found a failure to verify completion of corrective actions and failure to indicate the initiating corrective action document on a modification request that we identified in the report as violations for which enforcement discretion has been exercised. The NRC inspector also identified a concern in regard to the planned corrective action associated with a licensee event report.

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DETAILS

1. Persons Contacted

GSU

*D. L. Andrews, Nuclear Training Director R. E. Barnes, Codes and Standards Supervisor J. B. Blakley, Inservice Inspection (ISI) Supervisor G. M. Bratton, Level III *J. E. Booker, River Bend Oversight Manager B. M. Burmeister, Nuclear Licensing Engineer *J. L. Burton, Independent Safety Engineering Group (ISEG) Supervisor D. C. Byrd, ISEG Engineer *J. W. Cook, Lead Environmental Analyst *T. L. Crouse, Quality Assurance (QA) Manager *J. C. Deddens, Senior Vice President *L. A. England, Licensing Director M. S. Feltner, Nuclear Licensing Engineer *W. J. Fountain, QA Engineer *P. E. Freehill, Outage Manager *J. R. Hamilton, Design Engineering Director *G. K. Henry, Quality Operations Director B. S. Kievlen, Level III J. R. Langley, Balance of Plant (BUP) Design Supervisor D. N. Lorfing, Nuclear Licensing Engineer *J. W. Leavines, Field Engineering Director *I. M. Malik, Quality Systems Supervisor *C. L. Miller, Compliance Analyst *J. J. Pruitt, Management Systems Director D. L. Robinson, Field Engineer *M. F. Sankovich, Engineering Manager *J. P. Schippert, Operations Assistant Plant Manager *D. A. Shelton, Nuclear Licensing Engineer T. W. Stanberry, QA Engineer *K. F. Suhrke, Project Management Manager Stone & Webster *R. E. Buell, BOP Acting Supervisor

Rockwell International

W. R. Johnson, QA Manager

Cajun Electric

*W. L. Curran, Site Representative

NRC

*E. J. Ford, Senior Resident Inspector *W. B. Jones, Resident Inspector

*Denotes those persons that attended the exit meeting on May 19, 1989.

The NRC inspector also contacted other personnel including administrative and clerical personnel.

2. Followup on Previously Identified Inspection Findings (92701)

a. (Closed) Unresolved Item (458/8803-06): Manufacturer's input on failure of relays identified in Condition Report (CR) 87-1685.

The NRC inspector found that the licensee has documented input from the manufacturer on the relay failures identified in CR 87-1685. The manufacturer (Potter & Brumfield) has agreed with the licensee's disposition that this failure was an isolated case.

b. (Closed) Unresolved Item (458/8803-07): Review of the licensee's response to Generic Letter 83-28 in regard to CR 87-1540.

The NRC inspector found that the licensee has submitted in its letters Nos. 18521 and 21053, dated August 3, 1984, and May 20, 1985, respectively, its vendor interface program and received acceptance from NRC by a letter dated November 11, 1988. In regard to the key material used in Limitorque SMB-0-20 and -40 motor operators, it was found that the licensee has used acceptable materials as defined in NRC Information Notice 29-84. The Information Notice identifies 1018 steel as acceptable material. The NRC inspector did note that the licensee's Engineering Evaluation Analysis Request (EEAR) No. 88R-0348 performed as a result of the Information Notice erroneously stated that 4140 key material was used in one of the five operators of these types at RBS.

c. (Closed) Open Item (458/8803-09): Review of the licensee's program to monitor service water pipe.

The NRC inspector found this open item has been addressed in NRC Inspection Report 50-458/89-16. In that inspection report, the fouling of heat exchangers from corrosion products was reviewed and four followup items were identified.

3. Inservice Inspection Data Review and Evaluation (73755)

The objectives of this inspection were to ascertain whether the ISI data files are complete, and disposition of adverse finding and subsequent re-examination are consistent with regulatory requirements in regard to the recent feedwater inlet nozzle (1B13*D001-N4-A) indication. In this regard, the NRC inspector reviewed Technical Specifications (TS), Amendment 23, dated June 13, 1988, Section 17.2 of the Updated Safety Analysis Report (USAR), Revision 1, dated August 1988; and "Inservice Inspection Plan," Revision 3, dated August 2, 1988.

The NRC inspector found that Revision 3 of the ISI plan added 23 nozzles to the ISI scope as augmented inspections. This addition was based on the requirements identified in Generic Letter 88-01 and General Electric Service Information Letter No. 455. Intergranular stress corrosion cracking (IGSCC) had been found in safe end-to-nozzle weldments that utilized Inconel 182 weld buttering. The additional augmented ISI was performed during the current outage as part of the first period inspections of the first 10-year program. The results of the augmented inspection were that one indication was found in nozzle 1813*D001-N4-A; this indication exceeded the allowable limits of American Society of Mechanical Engineers (ASME) Section IX (IWB-3514).

The NRC inspector reviewed the records of ultrasonic (UT) examinations performed during this outage, preservice inspection, and computerized enhancement of the manufacturer's radiographs. As required by Generic Letter 88-01, the licensee has submitted a report, letter No. 308883, dated May 15, 1989, to the NRC of its findings. The NRC inspector found that the licensee was taking a conservative approach to this indication. The indication could not be confirmed as IGSCC cracking, but it was assumed that such is the case and crack growth will be re-examined during the next mid-cycle outage approximately 9 months from now.

No violations or deviations were identified in this area of the inspection.

4. Corrective Actions (92720)

The objectives of this inspection were to determine whether the licensee has developed a comprehensive corrective action program to identify, follow, and correct safety-related problems. In this regard, the NRC inspector reviewed Section 17.2 of the USAR, Revision 1, dated August 1988, and the following procedures:

- ADM-0019, "Initiation and Processing of Condition Report," Revision 8, dated February 27, 1989 with Temporary Change Notice No. 898-0615
- ADM-0035, "Preparation and Processing NRC Licensee Event, Special, and Safety Limit Violation Reports," Revision 21, dated October 29, 1987
- QAD-16, "Corrective Action," Revision 6, dated August 23, 1988
- RBNP-047, "Corrective Action Program," Revision 0, dated June 30, 1988

The NRC inspector found that the corrective action program was essentially the same as inspected previously (See NRC Inspection Report 50-458/88-03). This inspection reviewed the corrective action program in part, and a subsequent inspection will address the remainder of the program. The procedures which addressed internally identified problems and operational events were reviewed during this inspection and found to be programmatically satisfactory.

The NRC inspector reviewed the following Licensee Event Reports (LERs) and their associated CRs in regard to the identification of root causes, corrective actions, and the close out of corrective actions:

- LER 88-29 and CR 88-952 on an inadvertent autostart of annulus mixing and standby gas treatment systems due to a stuck check source in a radiation monitor
- LER 88-27 and CR 88-936 on inoperability of the reactor core isolation cooling (RCIC) system due to an incomplete construction modification
- LER 88-26 and CR-88-923 on inadequate filter application for safety-related damper due to a design error
- LER 88-25 and CR 88-905 on a RCIC system isolation due to a procedural error and personnel oversight
- LER 88-24 and CR 88-830 on a spurious reactor water cleanup (RWCU) system isolation during a temperature reading as part of a surveillance
- LER 88-23 and CR 88-764 on inoperable isolation valves
- LER 88-22 and CRs 88-821, -800, and -697 on a autostart of the fuel building (FB) ventilation treatment system due to a radiation monitor high signal

The NRC inspector's observations on the above were as follows:

° LER 88-25

The CR 88-25 associated with this LER was closed out on February 5, 1989. The NRC inspector found that the corrective action, in part, was to train all instrument and control (1&C) technicians on the event and to have I&C foreman accompany technicians to a job site and perform prejob briefings and assessments. In review of the training program attendance records, the NRC inspector found that when compared to an organization chart of the 1&C department of the same time frame, December 1988, that only 39 of the 43 personnel had received the training. The licensee, as a result of the NRC inspector's finding, then documented that one foreman and three I&C technicians were not trained in this regard on a new CR 89-0697. In that the specific observation has also been noted by the licensee, represents a minor regulatory concern with little safety significance, and appears it will be corrected within a reasonable time, no enforcement action is appropriate.

LER 88-24

In review of the CR associated with this LER, it was noted that there were additional corrective actions identified in the LER that were not identified in the CR. The LER identified corrective actions such as installation of a resistor to eliminate the voltage spike and installation of plaques to caution the operator to put the switches in bypass prior to taking readings. The corrective action to install plaques was taken as a result of the events associated with LER 86-51 and CR 86-1199. The installation of a resistor was taken because of an even earlier LER 85-51 and CR 85-0589. These steps taken as a result of the earlier associated events were not fully effective, resulting in the issuance of LER 88-24. The current corrective action as noted in CR 88-830 consisted solely of review and revision of surveillance procedures by the licensee.

LER 88-22

This LER had three revisions. Revision 0 was associated with CR 88-697 and an event on September 6, 1988. Revision 1 was associated with CR 88-800 and an event on October 11, 1988. Revision 2 was associated with CR 88-821 and an event on October 22, 1988. During these events, an engineered safety feature (ESF), the FB filter trains, was actuated because of a high signal from the radiation monitors. Each CR was closed upon the revision of the LER. CR-88-821 was closed on December 9, 1988, based, in part, on MR 88-312. Revision 2 of the LER stated the corrective action was to clean out the ductwork in accordance with a MWO 124752 and to revise set points of monitor 1RMS*RE5B in accordance with a MR 88-312. The LER and CRs stated that three other radiation monitors of the same model type, 1RMS-RE126, 1RMS-RE118, and 1RMS-RE124 had experienced the same problem of natural radon activity causing high signals. These radiation monitors had their set points changed in accordance with MR 87-0026, but in the engineering review of the MR, 1RMS*RE5B was overlooked. 1RMS*RE5B should have been included in MR 87-0026. The NRC inspector noted in review of the CR files that MR 88-312 had been cancelled on May 21, 1989, and replaced with MR 89-0032. An internal tracking item, on MR 88-312 No. 6990 was also erroneously closed. Rather than change the set points, MR 89-0032 removed the particulate channel of 1RMS*RE5B from the ESF initiation function. The NRC inspector questioned the licensee whether MR 89-0032, which was still in the design process, was not in conflict with USAR Sections 9.4.2.2.4 and 12.3.4.2.3.2. It was agreed by the licensee that a 10 CFR 50.59 review will be required, as well as a change to the USAR, if this MR were to be implemented. This MR was forwarded by the NRC inspector to the NRC Project Manager to alert him of this possible change to the USAR.

The RBS procedures allow for corrective actions to be documented via MRs. The CR in this case, because the events were documented as a LER, was reviewed by the Facility Review Committee (FRC) only in the LER format. The changed corrective action (from set point change to function elimination) was not submitted as a revised LER to the FRC because tracking item 6990 was erroneously closed. The licensee has agreed to submit a revised LER to reflect the current corrective action. RBS procedures require that all MRs receive FRC review. However, without the CR identification on the MR, as required by procedure, it was not readily identified that the MR was associated with a LER/CR. The MR did identify the closed tracking item. In that the specific observation has been corrected, appeared isolated and represents a minor regulatory concern with little safety significance, no enforcement action is appropriate.

A review of the circumstances and controls in place relative to evaluation of MR 89-0032 could not be completed during this inspection. This subject is considered an inspector followup item (458/8926-01).

5. Exit Meeting

An exit meeting was held on May 19, 1989, with those individuals denoted in Section 1 of this report. At this meeting, the scope of the inspection and the findings were summarized. The NRC resident inspectors also attended. The licensee did not identify as proprietary any of the information provided to, or reviewed by the inspector.